VERMONT

DOL FORM 5 (Rev. 5/05)

State File No. _____

DEPARTMENT OF LABOR
WORKERS' COMPENSATION DIVISION

EMPLOYEE'S NOTICE OF INJURY AND CLAIM FOR COMPENSATION

EMPLOYEE:

Name: _____

Street: _____

City: _____

State: _____ Zip: _____

DOB: _____

Social Security No.: _____

Telephone: _____

EMPLOYER:

Legal Name: _____

D/B/A: _____

Street: _____

City: _____

State: _____ Zip: _____

Owner/Supervisor Name: _____

Telephone: _____

INJURY:

Date of Injury: _____ Body Part Injured: _____

Job Site Location: _____ Machine or Tool Involved: _____

Did you notify your employer/supervisor at the time of the injury/illness? Yes ☐ No ☐

Briefly explain how injury/illness occurred:

_____

EMPLOYEE SEEKS COMPENSATION FOR:

Lost time benefits: _____ Medical benefits: _____ Both: _____

If claiming lost time benefits, indicate period of lost time. From: _____ To: _____

In either case, if claiming lost time or medical benefits, medical documentation MUST be attached.

_____ _____

Employee Signature Attorney Signature

*** * * TO BE COMPLETED BY THE DEPARTMENT OF LABOR * * ***

Workers' Compensation Insurance Carrier:

Policy Period: _____ To: _____

Policy Number: _____ Policy Cancelled: _____